Roots and Branches
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Tucker, GA 30084

SYMPTOM SURVEY

Name ___________________________________

To assist in your evaluation, please answer the following questions by checking yes or no:

Have you or do you experience...

Yes	No	
____	____	premenstrual syndrome?
____	____	witnessing a traumatic event?
____	____	recent weight loss?
____	____	recent weight gain?
____	____	recent loss of a loved one?
____	____	financial stresses?
____	____	problems with legal authorities?
____	____	any history of mental illness in your biological family?
____	____	alcohol or drug abuse in your biological family?

Please answer the following questions by checking the appropriate response:

Do you...

Always	Most of the time	Some of the time	Never	
_____	_____	_____	_____	have recurrent dreams?
_____	_____	_____	_____	have nightmares?
_____	_____	_____	_____	avoid specific events or places?
_____	_____	_____	_____	have an exaggerated startle response?
_____	_____	_____	_____	feel restless?

Always	Most of the time	Some of the time	Never	
______	______	______	______	feel sad or empty?
______	______	______	______	feel worthless?
______	______	______	______	have a diminished sense of pleasure?
______	______	______	______	have a desire for excessive sleep?
______	______	______	______	have thoughts of death?
______	______	______	______	have suicidal thoughts?
______	______	______	______	have homicidal thoughts?
______	______	______	______	become easily distractible?
______	______	______	______	fear criticism?
______	______	______	______	feel inferior to others?
______	______	______	______	have difficulty making decisions?
______	______	______	______	have difficulty expressing disagreement?
______	______	______	______	fear being alone?
______	______	______	______	make decisions based on impulse?
______	______	______	______	have low self-esteem?
______	______	______	______	have little desire for sexual contact?
______	______	______	______	desire to stay at home?
______	______	______	______	feel tired?
______	______	______	______	have difficulty concentrating?
______	______	______	______	feel guilty?
______	______	______	______	have difficulty staying organized?
______	______	______	______	feel irritable?
______	______	______	______	feel out of control?
______	______	______	______	feel lonely?
______	______	______	______	become physically violent?

Always	Most of the time	Some of the time	Never	
_______	_______	_______	_______	have difficulty going to sleep?
_______	_______	_______	_______	have difficulty staying asleep?
_______	_______	_______	_______	feel nervous or shaky inside?
_______	_______	_______	_______	think that someone can control your thoughts?
_______	_______	_______	_______	feel that others are the cause of your problems?
_______	_______	_______	_______	have pains in your heart or chest?
_______	_______	_______	_______	experience fear in open spaces?
_______	_______	_______	_______	have significant changes in appetite?
_______	_______	_______	_______	feel suspicious toward others?
_______	_______	_______	_______	feel something is wrong with your mind?
_______	_______	_______	_______	have difficulty sitting still?
_______	_______	_______	_______	feel unappreciated by others?
_______	_______	_______	_______	feel nervous when alone?
_______	_______	_______	_______	have feelings of terror?
_______	_______	_______	_______	have little or no closeness with others?
_______	_______	_______	_______	feel uneasy in crowds?
_______	_______	_______	_______	have angry outbursts?
_______	_______	_______	_______	have difficulty completing tasks?
_______	_______	_______	_______	have little interest in ordinary life?
_______	_______	_______	_______	feel that people dislike you?
_______	_______	_______	_______	feel nauseated?
_______	_______	_______	_______	throw up?
_______	_______	_______	_______	feel easily hurt?

Always	Most of the time	Some of the time	Never	
_______	_______	_______	_______	have choking sensations?
_______	_______	_______	_______	feel that others are watching or talking about you?
_______	_______	_______	_______	check and double-check what you do?
_______	_______	_______	_______	fear traveling on public transportation?
_______	_______	_______	_______	feel self conscious around others?
_______	_______	_______	_______	have urges to break or smash something?
_______	_______	_______	_______	feel hopeless?
_______	_______	_______	_______	find your mind going blank?
_______	_______	_______	_______	have trouble catching your breath?
_______	_______	_______	_______	feel you deserve to be punished?
_______	_______	_______	_______	argue frequently with others?
_______	_______	_______	_______	feel depressed?
_______	_______	_______	_______	experience mood swings?
_______	_______	_______	_______	have obsessive thoughts?
_______	_______	_______	_______	feel tense or anxious?
_______	_______	_______	_______	have physical problems due to emotional stress?
_______	_______	_______	_______	have hallucinations?
_______	_______	_______	_______	have trouble with short-term memory?
_______	_______	_______	_______	have trouble with long-term memory?
_______	_______	_______	_______	become hostile?
_______	_______	_______	_______	have dissociative episodes?
_______	_______	_______	_______	have conflicts with authority figures?
_______	_______	_______	_______	cry?
_______	_______	_______	_______	isolate yourself rather than participate in social activities?

Alcohol use: _____ never, _____ less than 1 time a month, _____ 1-4 times a month,

_____ 2-3 times per week, _____daily.

Typically, how many ounces do you consume at one sitting? _____ ounces

Use of illegal substances: _____never, _____ less than 1 time a month, 1-4 times a month,

_____ 2-3 times per week, _____ daily. Substance(s): ____________________________

Tobacco use: _____ never, _____ cigarettes per day.

Caffeine: _____ never, _____ caffeinated drinks per day.

Medication:

Are you allergic to any substances? YES _____ NO _____

If yes, please list the types of substances:

____

____

____

Are you currently on medication for reasons of mental health? YES _____ NO _____

If yes, what medication(s) and dosage(s) are you on?

____

____

____

If yes, please list the name, address and phone number of the prescribing physician:

____

____

____

Date of last physical exam: _________________________________

Are you currently on prescription medication for reasons other than mental health?
YES ____ NO ____

If yes, what medication(s) and dosage(s) are you on?

____

____

____

If yes, please list the name, address and phone number of the prescribing physician:

____

____

____

____

Prior Treatment:

Have you previously undergone any mental health treatment? YES ____ NO ____

If yes, who was/were your provider/s?

____

____

____

If yes, during what periods of time?

____

____

What is your reason for seeking counseling today?

____

____

____